Attestation of Completeness and Accuracy
Hospital Discharge Data Reporting

Facility Name: _____

Reporting Period: _____ Deadline Date: _____

Discharge Data File Type(s) (check all that apply):

☐ Hospital Inpatient ☐ Hospital Emergency Department

ATTESTATION BY ADMINISTRATOR OF FACILITY OR DESIGNEE

☐ I attest that, to the best of my knowledge and belief, all information in the above referenced hospital discharge data report(s) is accurate and complete.

OR

☐ I have personal knowledge that some of the information in the above referenced hospital discharge data report(s) is not accurate or not complete. I attest that, to the best of my knowledge and belief, all information in the report(s) is accurate and complete, except the information identified in a document accompanying this form that:

1) Describes the inaccurate or incomplete information and the circumstances that make the information inaccurate or incomplete, and
2) States what actions the hospital is taking to correct the inaccurate information or make the information complete.

_____ _____
Printed Name Title

_____ _____
Signature (Administrator of Facility or Designee) Date

NOTE: This form must have an original signature, and must be submitted by mail. Electronic or faxed copies will not be accepted.

Mail completed form to: Arizona Department of Health Services
Discharge Data Review
150 N. 18th Ave., Suite 550
Phoenix, AZ 85007-3248